Release of Information Consent for Insurance Benefit Verification

Client Name:		DOB:	
Parent/Guardian Name:		Parent/Guardian Phone Number:	
Address:			

CONSENT

I authorize A.P.P.L.E Consulting to obtain and/or release information regarding my child/myself regarding services provided to my child/myself verbally, in-person, via telephone or in written form, pertinent to services provided at A.P.P.L.E Consulting, as indicated below. I understand that any exchange will be handled with strict confidentiality. This consent shall expire one (1) year from the date of signature. I understand I may revoke my consent in writing at any time except to the extent that action has already been taken in reliance on it.

Parent/Guardian Signature _____ Date _____

Please do not obtain information from any professionals or individuals regarding my family member.
OR:

Please obtain information from the listed professionals or individuals regarding my family member.
Check all that apply:

☐ Insurance Company	Name:		
Phone:		Email:	

☐ Primary Care Physician MUST BE FILLED OUT	Name:		
Phone:		Email:	

☐ Other	Details:		
Phone:		Email:	